The Holliswood Hospital *and* Local 1199, Drug, Hospital and Health Care Employees Union, Petitioner. Case 29–RC–8085

November 22, 1993

ORDER DENYING REVIEW

BY CHAIRMAN STEPHENS AND MEMBERS DEVANEY AND RAUDABAUGH

The National Labor Relations Board has considered the Employer's request for review of the Regional Director's Decision and Direction of Election (pertinent portions of which are attached as an appendix), as well as the Petitioner's opposition brief. The request for review is denied as it raises no substantial issues warranting review.[1]

[1] Review was requested of the Regional Director's findings that the petitioned-for units of registered nurses and of all nonprofessionals were appropriate for bargaining.

APPENDIX

DECISION AND DIRECTION OF ELECTION

The Petitioner seeks an election in two separate units: (a) all registered nurses, excluding all other employees, managerial employees, guards, and supervisors as defined by the Act; and (b) all nonprofessional employees, excluding all other employees, professional employees, managerial employees, guards, and supervisors as defined by the Act.[4] The Employer takes the position that the only appropriate unit herein is a single, wall-to-wall unit of all professional and nonprofessional employees.[5]

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There is no history of collective bargaining for any of the Employer's employees.

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The Bargaining Units

The record evidence shows that the Employer operates a 100 bed private, for profit, psychiatric hospital that provides acute psychiatric care for adults and adolescents with psychiatric disorders.[7] The Employer provides 24-hour nursing care for its patients. The Employer is licensed by the State of New York as a psychiatric hospital and is accredited by the Joint Commission for Accreditation of Health Care Organizations (the Joint Commission). The Employer has four, 25 bed units (or programs) designated as follows: the adolescent unit, the behavioral disorders unit, the intensive treatment unit and the dual diagnosis unit. The average length of stay for patients in all units is ''approximately one month.''[8] The averages for individual units range from 24 to 25 days (dual diagnosis unit), to 28 days (intensive treatment unit), to 29 days behavioral disorders unit), to 32 to 33 days (adolescent unit). The Employer employs about 54 ''regular'' professional employees and 89 ''regular'' nonprofessional employees.[9]

The Employer occupies two interconnected buildings (referred to as the clinical building and the administrative building) on a 6 acre site. In the ''cellar'' of the clinical building, there is a patient and staff dining room, kitchen, and power plant. On the first floor, there is the lobby, the atrium (large meeting room), a conference room, various admissions offices, classrooms (for the adolescent patients), and creative therapeutic activities rooms/studios (for all patient). Also, various departmental offices (nursing, psychology, social work, creative therapeutic activities) are located on the first floor, as well as the pharmacy, staff lockers, and storage areas. On the second floor, there is a gymnasium with a weight room and recreation room. On the third floor, located above the weight and recreation rooms, there is an area called the ''mezzanine'' with offices for the education coordinator and teachers (for the adolescents), registered dietician, dietary technician, and discharge planner.

The clinical building also houses the four, 25 bed units: the behavioral disorders unit (2 North) and the adolescent unit (2 South) are located on the second floor; the dual diagnosis unit (3 North) and the intensive treatment unit (3 South) are located on the third floor. Each unit has patient rooms, a dining room/meeting room, a patient lounge, a staff lounge, a nursing station and medication room, a physical examination room, housekeeping and laundry rooms. In central areas on the second and third floors, there are offices for the program directors, unit secretaries, psychologists and social workers, a large meeting room, and a patient ''seclusion'' room for use by both units.

In the ''basement'' of the administrative building, there is a mailroom, central supply area, maintenance shop, housekeeping offices, and creative therapeutic activities staff offices. On the first floor, there are offices for payroll, accounts payable, data processing, accounts receivable and the human resources department. On the second floor, there are offices for the executive director, administrator, and the community relations department.

As noted, Randy Hampton serves as the Employer's executive director and chief executive officer. Hampton testified

[4] The units appear as amended at the hearing.

[5] Pursuant to Sec. 9(b)(1) of the Act, the Employer acknowledges the need for a ''self-determination'' election for the professional employees. See *Sonotone Corp*., 90 NLRB 1236 (1950).

[7] Some psychiatric patients are admitted with physical problems, such as diabetes and hypertension, which require medical attention during their stay.

[8] This is based on the testimony of Randy Hampton, the Employer's executive director and chief executive officer. Her individual unit figures result in an average stay of about 28 days.

[9] This is set forth on Emp. Exh. 73, ''Nonsupervisory Staff as of March 1993,'' a summary prepared by Executive Director Hampton showing all nonsupervisory employees by job classification, based on payroll records for March 1993. This summary also shows the Employer employed 61 professional per diem employees (47 as registered nurses), and 31 nonprofessional per diem employees. Hampton testified that she included all per diem employees employed at that time, regardless of the number of hours worked for any period of time. Hampton also testified that three professional positions (a psychologist, a creative therapeutic activities therapist, and an addiction counselor) and one nonprofessional position (medical transcriptionist) were vacant at that time. Hampton testified that there were ''probably'' vacant positions for registered nurses and mental health workers as well.

that the Employer's organizational structure is a ''matrix'' with reporting relationships delineated by department and by unit/program. Hampton has overall responsibility for the Employer's administrative, financial, and clinical operations. Jim Aranda serves as the Employer's administrator and chief financial officer. Administrator Aranda, the medical director, and the directors for clinical services, nursing, human resources, community relations, and dietary services report to Executive Director Hampton. The directors for pharmacy, housekeeping, and environmental services, and the business office manager, as well as various other business areas, report to Administrator Aranda. The four unit chiefs and their team leaders report to the medical director, all of whom are physicians. The directors for social services, psychology, creative therapeutic activities, and the four program directors report to the director of clinical services. Four nursing care coordinators, three clinical nursing supervisors, and the staff development coordinator report to the director of nursing, all of whom are registered nurses (RNs).

The Employer provides a multidisciplinary treatment approach in its four units and offers several treatment modalities including individual and group therapy, family therapy, psychopharmacology (medication), milieu therapy (safe, supportive patient environment) and self-help/support groups (e.g., Alcoholics Anonymous). With respect to clinical staffing patterns, the units are quite similar. Each unit has a unit chief, team leader, program director, a nursing care coordinator, one psychologist, three social workers, and three creative therapeutic activities staff members (CTA staff).[10] In addition, on the day shift and evening shift, there are two RNs[11] and two or three mental health workers; on the night shift, there is one RN and one or two mental health workers.[12] In addition to the foregoing members of the multidisciplinary treatment team, there is an education coordinator who works on the adolescent unit, an eating disorder coordinator who works on the behavioral disorders unit, and an addiction counselor who splits his time between the adolescent unit and the behavioral disorders unit. The Employer also employs a pharmacist, a biofeedback therapist, a registered dietician, and a discharge planner who provides services for all the units. The parties stipulated that the unit chiefs and team leaders (physicians), program directors (one psychologist and three social workers), and nursing care coordinators (RNs) are excluded from any unit based on supervisory status. The parties stipulated that all members of the multidisciplinary treatment team are professional employees, with the exception of the mental health workers and the licensed practical nurse; the parties agreed that they are nonprofessional employees. The parties stipulated to the professional status of the pharmacist, the biofeedback therapist, and the registered dietician, but they could not agree as to the professional status of the discharge planner.

Within 8 hours of admission, a patient receives a nursing assessment conducted by an RN, which includes an initial nursing care plan for the patient. Within 24 hours, a physical examination is conducted by a physician. Within 7 days, the patient also receives separate psychiatric, psychosocial, and creative therapeutic activities assessments.[13] All patients receive psychological and nutritional screenings and, if necessary, complete assessments. The various assessments are placed in the patient's medical record (chart) which is maintained at the nursing station on the patient's unit. Within 7 days of admission, the multidisciplinary treatment team meets in clinical ''rounds'' to formulate a treatment plan based on the various assesments. The treatment plan contains specific treatment interventions, with goals and objectives tailored to the patient. Each discipline represents a component of the treatment plan which, through interdisciplinary collaboration and coordination, maximizes the benefits of the patient's hospitalization. The treatment plan is written on a special form and placed in the patient's chart. The various disciplines complete progress notes related thereto, which are kept in the patient's chart. The multidisciplinary team reviews the treatment plan every 7 days. In addition to the various assessments, treatment plan and progress notes, the patient's chart also contains admitting forms, patient care monitoring forms, medication and special precaution orders, vital signs forms, observation flow sheets, laboratory reports and a discharge/aftercare plan.

The Employer has a department of nursing headed by a director of nursing. The Nursing Department Policy Manual contains numerous, detailed policies and procedures which apply to the nursing staffs.[14] The department of nursing utilizes the American Nursing Association Standards of Psychiatric and Mental Health Nursing Practice.[15] Four nursing care coordinators, three clinical nursing supervisors, a staff development coordinator, and an administrative assistant report directly to the director of nursing. With the exception of the administrative assistant, all are RNs and Section 2(11) supervisors. The nursing staff provides nursing care 24 hours a day, 7 days a week, 365 days a year, on all four units. The State of New York and the Joint Commission require that every nursing unit has at least one RN in charge at all times. There are three shifts for nursing staffs: 8 a.m. to 4:30 p.m. (day); 4 p.m. to 12:30 a.m. (evening); and 12 a.m. to 8:30 a.m. (night). Nursing staffs work every other weekend, and four of eight holidays a year. Nursing staffs are subject to a mandatory overtime policy; RNs are the only professional employees so affected. Nursing staffs are assigned to specific units, but they may be reassigned to another unit for an entire shift or part of a shift due to staffing needs.[16]

Each unit has a nursing care coordinator who has 24-hour accountability for the standard of nursing care provided by the nursing staff on her unit. The RNs, the LPN, and the mental health workers report directly to her. The nursing care coordinator works Monday through Friday, 8 a.m. to 4:30 p.m., and, at her discretion, she may ''flex'' her hours into the evening shift. There is a clinical nursing supervisor assigned to the evening shift and to the night shift; she is

[10] The CTA staff consists of art therapists, dance/movement therapists, a recreation therapist, and an occupational therapist.

[11] There is an exception in the case of the adolescent unit where there is one RN and one LPN on the day shift. If absent the LPN is replaced with an RN.

[12] These are ''base'' staffing patterns and staff may be increased due to patient acuity.

[13] The psychosocial assessment is done by a social worker, and the creative therapeutic activities assessment is done by a member of the CTA staff.

[14] See P. Exhs. 1 and 2.

[15] See P. Exh. 1, NSG-I-3.0.1.

[16] The Employer's director of nursing, Majorie Witt, testified that such reassignments occur about once a week and are necessitated by patient emergencies, staff absences, and patient acuity levels.

deemed to be responsible for the ''overall direction and leadership'' of the nursing staff on her shift and is the ''designee'' of management on her shift.[17] The staff development coordinator has overall responsibility for the education and training of the nursing staffs, and she participates in training other disciplines and in quality assurance activities.

The Employer's requirements for an RN are graduation from an accredited school of professional nursing and a current license from the State of New York. The Employer prefers a Bachelor's degree, experience in a psychiatric nursing unit, and 1 year's experience as an RN.[18] The RN provides professional nursing care utilizing nursing methods and techniques on his or her assigned unit.[19] These include the ''nursing process'' (assessment, planning, implementation, and evaluation) related to the individual patient's nursing care plan, patient/family teaching, and the maintenance of a therapeutic milieu for the patient.[20]

At the start of every shift, the nursing staffs receive the ''inter-shift report'' from the previous shift.[21] The intershift report is a status report on the unit which includes admissions, discharges, patient incidents and special orders. On every shift, an RN and a mental health worker are assigned to respond to a ''code white'' (patient psychiatric emergency) on other units. On every shift, each patient is assigned either an RN or a mental health worker as his or her ''primary contact'' for the shift. The primary contact must meet with the patient and assess the patient's condition and behavior. For every admission, an RN must complete a nursing assessment record which includes the initial nursing care plan for the patient. The nursing assessment provides a detailed medical history, past and present, of the patient's physical and mental health, and substance abuse, if any. The RN conducts the patient's initial orientation to the unit. For every discharge, the RN must meet with the patient to ensure his or her understanding of the discharge/aftercare plan and make a record of their meeting.

On every shift, an RN must complete a patient acuity assessment form which reports the patient census and individual patient acuity ratings (reflects the severity of the patient's symptoms and special orders related thereto); the nursing care coordinator can recommend that additional staff be assigned to the unit based thereon. The patient care monitoring form must be completed by the nursing staffs for each patient for each shift.[22] If a member of the nursing staffs other than an RN completes the form, an RN must cosign it. This form reflects the patient's status (e.g., special orders) and the patient's responses to interventions. These form are used for the intershift report and clinical rounds. In addition to the patient care monitoring form, an RN must make an entry on the patient's progress notes a minimum of once in 24 hours.[23] In the following circumstances, the nursing staffs also must make an entry on the patient's progress notes: patient's response to medication dispensed ''prn'' (as needed), off ground passes, therapeutic passes, patient incident, or change in behavior or medical status.[24] The vital signs form records the patient's pulse, blood pressure, temperature, and weight. The observation flow sheets refer to specific ''precautions'' or restrictions for the patient, e.g., constant supervision related to suicide risk, public area restriction, or guarterly checks (every 15 minutes). There is a separate observation flow sheet for each shift (day, evening, and night) with sections marked by the quarter hour for observation notes. The vital signs form and the observation flow sheets are completed by nursing staffs and are maintained in the ''Nursing Observations'' section of the patient's chart.

On the day and evening shifts, one RN is assigned as the ''charge nurse'' and the other RN is assigned as the ''medication nurse'' on the unit.[25] On the night shift, the RN must function in both roles. The medication nurse's principal function is the administration of medication on his or her unit. Virtually all the patients on the intensive treatment unit, and most of the patients on the dual diagnosis unit, take prescribed medication; and medication is administered on the other units as well. The Department of Nursing Policy Manual delineates the extensive procedures and documentation related to the administration of medication. The medication nurse interacts mostly with physicians. The medication nurse on the day and evening shifts also serves as a ''primary contact'' for patients on his or her unit.

On Monday through Friday, from 9 to 9:45 a.m. or 10 a.m., clinical rounds are held on each unit. The nursing care coordinator and the charge nurse attend as the representatives of the nursing staffs.[26] At rounds, the charge nurse usually reads the nursing intershift report from the evening and night shift. Each patient's status is discussed briefly, and specific patient problems can be raised by any team member. As noted, the team formulates the individual treatment plans at rounds; each discipline proposes its component of the plan in response to the specific problems identified in the patient's psychiatric assessment. The treatment plan is written on a special form and placed in the patient's chart. Either one team member is assigned to write the complete treatment plan, or a member of each discipline writes his or her component of the treatment plan.[27] The treatment team also reviews the treatment plan at set intervals during the patient's

[17] Director of Nursing Witt testified regarding the duties of the clinical nursing supervisor using vague descriptions and offering few specifics. In the absence of a clinical nursing supervisor, an RN is designated the ''Senior Nurse'' on the evening and night shifts.

[18] For other professional job classifications, the Employer requires a minimum of a Bachelor's degree, except for the recreation therapist.

[19] See Emp. Exh. 62, ''Position Description'' for RNs.

[20] It should be noted that under the ''Standards of Practice'' contained in the Department of Nursing Policy Manual, the section entitled ''Psychotherapy'' has been deleted by hand; the Employer's nursing staffs do not function as psychotherapist.

[21] This requires all nursing staffs to remain one-half hour into the next shift.

[22] ''Nursng staffs'' refers to the RNs, the LPN, and the mental health workers who report to the nursing care coordinator on their unit.

[23] The patient's chart has a section marked ''Progress Notes'' where all disciplines make entries related to their component of the multidisciplinary treatment plan.

[24] An RN must cosign any entry made by a mental health worker, and an RN or LPN must make an entry regarding medication or medical status.

[25] The sole LPN, assigned to the adolescent unit, can administer medication. No member of any other unit job classification is allowed to administer medication.

[26] One mental health worker may attend rounds depending on patient acuity on the unit.

[27] On at least one unit (dual diagnosis unit), the nursing care coordinator writes the nursing care plan component of the treatment plan.

hospitalization. Depending on the unit, this review is done during rounds or in a separate meeting. Immediately after rounds, the nursing care coordinator or the charge nurse gives a ''post-rounds report'' to the other members of the nursing staffs.

Two units hold multidisciplinary staff meetings on such topics as policy and procedures issues, administrative matters, and quality assurance/improvement activities on a weekly basis; the other units hold them biweekly or monthly.[28] The nursing care coordinator attends, as well as one RN. The nursing care coordinators conduct meetings for the nursing staffs only on their units on a biweekly or monthly basis.

During clinical rounds, the treatment team can decide to ''team'' a patient. ''Teaming'' is a treatment intervention whereby two or more members of the patient's treatment team confront the patient with certain problematic behavior in order to reinforce treatment plan goals. Members of the nursing staffs are often involved in teaming a patient with other members of the treatment team. A teaming can last from 5 minutes to 30 minutes with an average about 15 minutes. The treatment team also can decide to enter into a ''contract'' with a patient whereby the patient is expected to self-monitor certain problematic behavior and record data related thereto; contracts run for 1 to 3 days. The patient's contract is kept at the nursing station on the patient's unit. The nursing staffs monitor the patient's compliance with the contract and keeps other members of the treatment team informed as to the patient's compliance or noncompliance.[29] Although the frequency of contact between RNs and other members of the treatment team varies by individual and by unit, it consists mostly of brief conversations regarding patient behavior on the unit or in a group.

The nursing staffs lead didactic groups for patients, e.g., RNs conduct medication education groups. Some mental health workers colead or alternately lead groups with other disciplines such as a drama workshop or ''stretch'' with CTA staff, or a meal preparation group with the registered dietician. Although there is some general testimony that ''nurses'' colead patient groups with other disciplines, the record evidence does not establish that *unit* RNs colead or alternately lead patient groups with other nonsupervisory members of the treatment team, except on the dual diagnosis unit where a per diem RN coleads a ''women's group'' with a social worker.[30]

Other than physicians, RNs are the only members of the treatment team who can initiate seclusion or restraint for a patient. The Department of Nursing Policy Manual delineates the specific procedures and special documentation related thereto. RNs also can initiate a ''code white'' (patient psychiatric emergency). All members of the treatment team receive ''management of the aggressive patient'' (MAP) training and are expected to respond to a ''code white'' on their unit. However, only nursing staffs are assigned by shift to respond to a ''code white'' on other units. Either the charge nurse or the nursing care coordinator functions as the leader of a ''code white'' and assigns roles to the other participants (e.g., to act as the ''communicator'' or to hold the patient's limbs).[31] RNs can initiate body searches and room searches. Nursing staffs must be trained in cardiopulmonary resuscitation, and only physicians and nursing staffs respond to a ''code blue'' (patient medical emergency). Nursing staffs monitor patients in the process of drug detoxification, which requires specific documentation. Only RNs can initiate intravenous therapy and prepare and monitor a patient receiving electroconvulsive therapy. RNs must report and document medication errors and any adverse drug reactions, which are reviewed by the pharmacy and therapeutics committee.

There is considerable record evidence regarding the contact between RNs and other professional employees who provide patient services on a unit. The record evidence shows that the multidisciplinary treatment approach encourages collaboration and cooperation among members of the treatment team. However, the record evidence also shows that the collaboration and cooperation associated with a multidisciplinary treatment approach primarily affects the RNs assigned to the day shift, as there is minimal contact between RNs and other professionals on the evening shift and virtually none on the night shift.[32]

Director of Nursing Witt testified regarding the differences in the role of an RN in an acute care hospital and an RN at the Employer's facility, based on her experience. Witt testified that at the Employer's facility, although the RN exercises independent judgment in designing and implementing the nursing plan of care, it is consistent with and supports the multidisciplinary treatment philosophy. At an acute care hospital, the RN designs and implements the nursing plan of care independently of the individual treatment plans developed by each distinct discipline. Witt also testified that at the Employer's facility, there is much more ''collaboration and sharing'' between RNs and other disciplines related to the multidisciplinary treatment plan. At an acute care hospital, although working in the same environment, RNs and other disciplines do not necessarily share the outcome of their therapeutic interventions. Witt also testified that patients are admitted to acute care hospitals because they require nursing care, whereas patients are admitted to psychiatric facilities because they require treatment by several disciplines. In a psychiatric facility, the maintenance of a ''therapeutic milieu'' (safe, supportive patient environment) is a key treatment approach facilitated by nursing staffs, which is not provided in an acute care hospital.

The Employer employs 22 ''regular'' RNs and 47 per diem RNs. No other professional job classification relies so

[28] Quality assurance/improvement activities are conducted on the basis of a unit/program or a department.

[29] Several witnesses had difficulty attempting to estimate the frequency of teaming or contracts on the various units. It appears that teaming and contracts occur mostly on the adolescent unit, and to a lesser extent on the behavioral disorder units.

[30] The Employer offered a list of groups coled or alternately led by ''nursing staffs'' and other disciplines through Edward Spauster, its director of clinical services. (See Emp. Exh. 71.) However, Spauster's cross-examination related thereto shows that *nonunit* staff (e.g., a program director) colead or alternately lead groups with *unit* RNs (not a nursing care coordinator or the director of nursing), except as mentioned above. (See Spauster, Tr. 1851–1872.) Even if there was more evidence to show that unit RNs colead or alternately lead patient groups with other nonsupervisory members of the treatment team, it would not affect my conclusions regarding the appropriate bargaining units herein.

[31] Director of Nursing Witt estimated that a ''code white'' occurs several times a week.

[32] See testimony of RNs Daphne James, Doris Brown, Fred Pelczynski, and Joanne Haws.

heavily on per diem employees. The Employer employs 33 non-RN professional employees, 14 non-RN professional per diem employees, 51 ''regular'' nonprofessional employees, and 22 nonprofessional per diem employees.[33]

The other members of the nursing staffs are the LPN and the mental health workers. There is one LPN who is assigned to the adolescent unit. The Employer's requirements for the LPN position is a New York State license as a practical nurse, with related experience preferred. The LPN performs virtually all the functions of an RN, under the supervision of an RN, including the administration of medication; however, the LPN cannot serve as a charge nurse or perform the nursing assessment. When the LPN is absent, he is replaced by an RN. The incumbent LPN, who is also a certified addiction counselor, coleads a substance abuse group with his unit's program director.

As noted, there are mental health workers assigned to every unit, on every shift. The Employer has a single job description listing three titles: mental health worker, senior mental health worker, and mental health counselor. The Employer's requirements vary with the title: an Associate's degree in mental health and related experience for the mental health worker; Bachelor's degree in mental health for the senior mental health worker; a Bachelor's degree and 3 to 5 years' experience for mental health counselor. Although it would appear that these titles, and respective requirements, are utilized to set initial salaries, the Employer does not use these titles to differentiate among ''mental health workers'' regarding their duties and responsibilities.

The mental health workers provide direct patient care under the supervision of the nursing care coordinator or the charge nurse. In addition to the duties and responsibilities discussed above, the mental health workers assist in the admission of patients by orienting patients to the unit, performing body/belongings searches, obtaining routine laboratory specimens, and taking vital signs. They also monitor patient safety factors on the unit and assist in special observation procedures for patients at risk. Some mental health workers conduct community meetings and goals groups (referred to as ''milieu'' groups) on the units.[34] Mental health workers accompany patients to the dining room and gymnasium,[35] as well as to appointments inside and outside the Employer's facility. The parties agreed that the mental health workers are nonprofessional employees. There are 37 mental health workers and 9 per diem mental health workers.[36]

The Employer's requirements for a unit psychologist are a Doctorate in applied psychology, a New York State license as a psychologist, and 1 year's experience in an in-patient psychiatric setting. There are three psychologists, all of whom work 4 days a week, Monday through Friday. The psychologists report to the director of the psychology department.[37] The psychologists refer patients for psychological testing and analyze and report the findings to the treatment team.[38] The psychologists lead ''skill training'' groups for patients, such as anger management groups. They lead about two patient groups a day for their unit, and they record progress notes in the patients' charts once a week as related thereto. They also meet individually with patients on a consultation basis,[39] they develop behavioral management plans (''contracts'') for individual patients, and they serve as the ''cognitive behavioral treatment'' expert for the treatment team. In addition, they participate in formal marketing efforts as organized by the community relations department.

The Employer's requirements for a social worker are a Master's degree in social work and experience working with family and group modalities. There are 11 social workers who report to the director of the social work department. The eating disorder coordinator also reports to the director of social work and functions much like a social worker on her unit. There are three social workers assigned to each unit. They work 5 days a week, Monday through Friday; 1 day a week they ''flex'' their hours so as to work one evening (e.g., 12 noon to 9 p.m. rather than 9 a.m. to 5 p.m.). The social workers do the required psychosocial (comprehensive social work) assessment on every patient. The social workers lead various patient groups including women's group, survivors' group, and family roles group; and they meet with patient families. They make weekly progress notes and record all family contacts. They develop individual discharge/-aftercare plans in consultation with the treatment team. They also participate in formal marketing efforts.

The CTA staff consists of one recreation therapist, one occupational therapist, four art therapists, and three dance therapists. The CTA staff report to the director of CTA, who also serves as a dance therapist. The CTA staff works 5 days a week, including 1 weekend day. Two CTA staff members work until 8 p.m., 4 days a week.

The Employer's requirements for a recreation therapist are a minimum of an Associate's degree in recreation therapy, 2 years' experience in recreation therapy, and registration with the National Therapeutic Recreation Society. The Employer's requirements for an occupational therapist are a Bachelor's degree in occupational therapy and current certification and registration by the ''A.O.T.A.'' The Employer's requirements for an arts therapist are a Master's degree in art therapy and registration as an art therapist. The Employer's requirements for a dance/movement therapist are a Master's degree in movement therapy and registration as a movement therapist. All CTA staff do the required creative therapeutic activities assessment on assigned patients. They plan, organize, and conduct therapeutic programs in their specialties for the patients. They also formulate individual treatment plans and record patient responses thereto in patient charts. In addition, the CTA staff have marketing duties and provide clinical in-service training. The recreation therapist is assigned to

[33] See Emp. Exh. 13, ''Nonsupervisory Staff as of March 1993.''

[34] Although the highest requirement for the position is a Bachelor's degree, there are several mental health workers who have advanced degrees. Director of Nursing Witt testified that a mental health worker's responsibilities can vary according to the individual's abilities.

[35] The gymnasium used by the patients consists of a weight room and a recreation room; a CTA staff member accompanies patients to the weight room while the mental health worker accompanies them to the recreation room.

[36] See Emp. Exh. 73, ''Nonsupervisory Staff as of March 1993.''

[37] The director also serves as a unit psychologist.

[38] The Employer subcontracts the psychological testing to persons known as ''psychology technicians.'' As noted, the parties stipulated that they are not employees of the Employer and should be excluded from any unit found appropriate herein.

[39] The psychologists do not offer individual psychotherapy to patients; rather, they act as an adjunct to the individual psychotherapy provided by the unit psychiatrists.

the dual diagnosis unit but runs groups for all units. The occupational therapist is assigned to the intensive treatment unit. There is an arts therapist and a dance/movement therapist assigned to each unit.[40]

The Employer's requirements for the education coordinator are a Master's degree in special education and New York State certification in special education, and a minimum of 3 years' experience in special education. The education coordinator is assigned to the adolescent unit and report to the program director. She serves as the liaison between the Employer and the adolescent patient's home school system and his aftercare/discharge school system, if different. The education coordinator oversees the special education program provided by the New York City Board of Education at the Employer's facility for the adolescent patients during their in-patient stay to ensure that the clinical philosophy and goals are supported in the special education program. She also serves as the expert in psychosocial education for the treatment team.

The Employer's requirements for the eating disorder coordinator are a Master's degree, or ''Ph.D. prepared,'' and 5 years' experience. The eating disorder coordinator is assigned to the behavioral disorders unit; she works part time. Although the Employer's position description states that the eating disorder coordinator reports to the program director, the incumbent reports to the director of social work as she has her Master's degree in social work and is assigned a small social work caseload in addition to her other duties. In conjunction with the program director, she coordinates the clinical management and marketing efforts of the eating disorder program. She serves as the eating disorder specialist for the treatment team, leads eating disorder groups, and oversees such groups led by other disciplines. In conjunction with the community relations department, she engages in various marketing efforts for the eating disorder program.

The Employer's requirements for the addiction counselor are a Bachelor's degree (Master's preferred), New York State certification, and 2 years' experience. The addiction counselor splits his time between the behavioral disorders unit and the adolescent unit and reports to their program directors.[41] The incumbent addiction counselor works 32 hours a week. He serves as the liaison with the self-help community and is an expert on ''12-step'' programs. He facilitates patient groups on topics relevant to addiction and coordinates 12-step meetings at the Employer's facility. In conjunction with social workers, he facilitates family education programs related to addiction.

In addition to the foregoing members of the multidisciplinary treatment team who are assigned to specific units, there are other professionals who provide services related to patient care for all the units: the pharmacist, the biofeedback therapist and the registered dietician. As noted, the parties did not agree as to the professional status of the discharge planner.

The Employer's requirements for the pharmacist are a Bachelor's degree in pharmacy and New York State license and registration. The pharmacist works Monday through Friday, from 8 a.m. to 4 p.m., and she reports to the director of pharmacy.[42] The pharmacist compounds and dispenses medications and pharmaceutical supplies for all units. She performs monthly inspections of the nursing stations and medication rooms. The pharmacist maintains records known as ''patient profiles'' which are kept in the pharmacy. She distributes medication literature to the nursing staffs. Along with the director of pharmacy, she collects data on medication administration errors which pertains to nursing staffs only. She serves as a member of the pharmacy and therapeutics committee, along with the executive director, the laboratory manager, a physician, the registered dietician, and a nursing care coordinator. This committee is mandated by the Joint Commission and its members review and analyze all incidents of medication administration errors and adverse drug reactions and make recommendations for action related thereto.

The Employer's requirements for the biofeedback therapist are a Bachelor's degree, 2 years' experience, and membership in the Biofeedback Certification Institute of America. The biofeedback therapist reports to the director of psychology. She conducts biofeedback assessments and training sessions for patients from all units who are referred by the treatment team. She attends rounds to report on a patient's progress and records such progress in the patient's chart.

The Employer's requirements for the registered dietician are a Bachelor's degree in nutrition and food service, registration with the American Dietetic Association, and 1 year's clinical experience. She works from 9 a.m. to 5 p.m. and reports to the director of the food services department. The registered dietician conducts a nutritional screening on all patients, with a full assessment if necessary. She develops a nutrition care plan for patients with special needs, and she attends clinical rounds on all units on a regular basis to monitor and evaluate the patient's progress related thereto. The registered dietician conducts patient education groups and in-service training related to nutritional issues. She works most closely with the eating disorder program on the behavioral disorders unit. The registered dietician also spends about 20 percent of her time working with the staff of the food services department to develop and evaluate menus for all patients, as well as those with special dietary needs.

. . . The Employer's requirement for the discharge planner is a minimum of a Bachelor's degree in the social sciences (e.g., psychology or social work). The discharge planner reports to the director of social work. The incumbent discharge planner has a Master's degree in social work. Executive Director Hamptor testified regarding the duties and responsibilities of the discharge planner. In collaboration with the social work staff and the multidisciplinary treatment team, the discharge planner identifies community resources for utilization in the discharge/aftercare plans developed for all patients. She also clarifies insurance coverage for aftercare programs. She attends the weekly discharge planning rounds held on all units, along with the director of social work, program director, unit chief, and team leader. At times, the director of community relations and/or community relations representatives also attend the discharge planning rounds as the Employer seeks to use community resources

[40] As noted, the director of CTA is assigned to a unit as a dance/movement therapist.

[41] At the time of the hearing, the addiction counselor had tendered his resignation, and no replacement had been found for him.

[42] There are per diem pharmacists who work ''occasionally'' in the evening and on weekends.

who make referrals to the Employer's facility as part of the Employer's discharge/aftercare plans. The referral coordinators serve as a primary resource for the discharge planner to identify appropriate aftercare referrals, but she also identifies new community resources through her own community contacts and visits to community programs.

Hampton also testified that the discharge planner exercises independent judgment and discretion in the selection of appropriate aftercare referrals for individual patients; for example, the treatment team member will provide a ''picture'' of the patient and goals for the patient, and the discharge planner will decide the community resources appropriate for the patient. Hampton testified that the duties of the discharge planner are intellectual in character, such as the development of new community resources which requires creativity, the clarification of insurance coverage for aftercare programs which requires negotiation skills, and the visits to special programs in the community which reguires independent judgment in their evaluation for use in discharge/aftercare plans. The discharge planner receives MAP (management of the aggressive patient) training and is expected to respond to a ''code white.''

In addition to the aforementioned duties and responsibilities, the discharge planner also can substitute for an absent member of the social work staff.[43] When substituting for a social worker, the discharge planner can be assigned a patient caseload, conduct the required social work (psychosocial) assessment, and lead and colead patient groups. Prior to the conferment of her Master's degree, the discharge planner's work as a substitute social worker had to be supervised by, and her work product (e.g., a psychosocial assessment) had to be cosigned by, a Master's level social worker.

. . . .

. . . I find that the discharge planner is a professional employee within the meaning of the Act.

The Employer also employs unit secretaries and unit receptionists assigned to specific units. The Employer has no educational requirements for these two positions, and the parties agree that they are nonprofessional employees. There is a unit secretary assigned to each unit. They provide secretarial assistance for unit staff members, other than nursing staffs;[44] assemble materials for reports and questionnaires; maintain certain patient records; and order supplies. They take minutes at unit staff meetings. There are two unit receptionists who cover two units each (one per floor). They provide ''coverage'' at the nursing stations. They also maintain certain patient records, schedule patient appointments inside and outside the Employer's facility, and screen unit telephone calls. Both the unit secretaries and the unit receptionists provide ''back-up'' coverage for the nursing stations.

The Employer also employs professional employees in the department of community relations. Its director, also known as the director of marketing, reports to Executive Director Hampton. The community relations representatives (also known as ''marketing associates'') report to the director of marketing. The director of intake/referral and the admitting supervisor also report to the director of marketing. The referral coordinators report to the director of intake/referral. The parties stipulated to the supervisory status of the director of intake/referral and the admitting supervisor. At the hearing, the Employer took no position as to the professional status of the community relations representatives and the referral coordinators, and the Petitioner took the position that they are professional employees. However, in its brief, the Employer agreed that they are professional employees.[45]

The function of the community relations department is to ''maintain a census,'' that is, to ensure maximum patient admissions. The Employer's requirements for a community relations representative are a Bachelor's degree (Master's level preferred), experience, and affiliation/certification related to the field (e.g., a certified addiction counselor). They function like ''account executives'' in developing new referral accounts and maintaining existing accounts, and they handle the Employer's public relations through the media, advertising, community education events, and participation in community organizations. They have no contact with patients, but they have contact with the treatment teams through marketing meetings held weekly on each unit. However, the nursing staffs do not attend these marketing meetings. They have designed and implemented professional education series for the public utilizing members of the treatment teams. Two of the three incumbent community relations representatives have Master's level degrees; the other has a Bachelor's degree and is a certified addiction counselor and a certified employee assistance professional.

The Employer's requirements for a referral coordinator is a Master of Social Work, or a Bachelor of Science in Nursing, degree with psychiatric experience. The referral coordinators receive calls from various referral sources and screen individuals for admission. They complete the initial intake information, make a clinical assessment regarding admission, consult with a staff physician, and arrange the initial psychiatric interview. They also coordinate admissions with the staff of the benefits office and the admitting office. The two referral coordinators cover their office from 8 a.m. to 8 p.m., Monday through Friday. Both referral coordinators have a Master of Social Work degree.

As noted, the admitting supervisor also reports to the director of marketing. The admitting clerks, receptionists, and switchboard operators, all nonprofessional employees, report to the admitting supervisor. The Employer requires a high school diploma and experience for the admitting clerks; there are no educational requirements for the receptionist and switchboard operator positions. The admitting clerks prepare all necessary paperwork related to a patient admission, secure necessary signatures from patient or family, enter admission data into a computer, and notify the unit of an admission and patient arrival. They staff the admitting office from 9 a.m. to midnight, 7 days a week. From 8 p.m. to midnight, and

[43] There are 12 social workers on staff, all of whom are professional employees. Hampton first testified that the discharge planner is ''sporadically'' assigned to substitute for a social worker; Hampton later testified that she does so ''infrequently'' or ''a couple of times this year.'' However, Hampton did not elaborate as to the duration of such assignments.

[44] RNs and mental health workers do not require secretarial services.

[45] As there is no longer a dispute regarding the professional status of the community relations representatives and the referral coordinators, there is no need for a lengthy analysis regarding such status. I find that the record evidence supports the finding of the professional status of the community relations representatives and referral coordinators.

on weekends, the admitting clerks receive referral calls, do initial screening (nonclinical), and forward calls to referral coordinators if necessary. The receptionist sits in the lobby and receives all patients and visitors, directs them to the proper destination, and notifies the staff of the arrival of appointments and visitors. There is a receptionist on duty from 8 a.m. to midnight. The admitting clerks serve as the receptionist on weekends. The switchboard operator answers the telephone for the entire facility.

The business office manager reports to Administrator Aranda. The benefits office supervisor and the accounts receivable supervisor (also known as the patient accounts supervisor) report to the business office manager, all stipulated supervisors. There is one patient finance counselor, who reports to the benefits office supervisor. There is one patient accounts representative and one senior patient accounts representative who report to the accounts receivable supervisor. The Employer requires a high school diploma, a college degree preferred, and experience for the patient finance counselor; and a high school diploma, college preferred, for the patient accounts representatives. These employees work Monday through Friday, from 8 a.m. to 4 p.m. The parties agreed that they are nonprofessional employees.

The patient finance counselor calls health insurance companies to verify and precertify coverage for patient admissions. They complete part of a two-page form, the ''Insurance Communication Log,'' which is forwarded to them by a referral coordinator.[46] They meet with the patient and/or family regarding insurance coverage and arrange individual payment plans if necessary. They also maintain a weekly discharge list for all units and distribute it to management staff. The patient accounts representative processes all accounts receivable and collects moneys from insurance companies and patients and/or families. The senior patient accounts representative performs these same duties but also serves as the accounts receivable supervisor in her absence due to illness or vacation.[47]

The data processing supervisor, the accounts payable coordinator, and the payroll representative report to Administrator Aranda. There is one data processing clerk who reports to the data processing supervisor, who is a stipulated supervisor. The parties agreed that the data processing clerk, the accounts payable coordinator, and the payroll representative are nonprofessional employees. These three employees work from 8 a.m. to 4 p.m., Monday through Friday, and share an office with the data processing supervisor. The data processing clerk compiles and processes data from various departments using software known as the Meditech Information System. He also serves as the data processing supervisor in her absence due to illness or vacation. The Employer requires a college degree and computer knowledge and experience, for the data processing clerk position. The accounts payable coordinator receives and processes purchase requisitions, processes invoices and voucher packages, and secures timely payments for vendors. The Employer requires a high school diploma, college preferred, and related experience for the accounts payable coordinator position. The payroll representative processes all paperwork necessary to the generation of biweekly payroll and performs certain purchasing functions. The Employer requires a high school diploma, and related experience for the payroll representative position.

The director of the housekeeping department reports to Administrator Aranda. Housekeepers and floormen/projectmen report to the director of housekeeping. They maintain assigned areas in a clean, sanitary, and orderly condition. In addition, the floormen/projectmen periodically strip and buff floors and shampoo rugs throughout the facility. The housekeeping staff are given instructions on how to interact appropriately with psychiatric patients and are expected to report ''problems'' to the nursing station, for example, the discovery of contraband in a patient's room, or the refusal of a patient to leave a room for cleaning purposes. The housekeeping staff works 7 days a week, from 8 a.m. to 4 p.m. on weekdays, and from 11 a.m. to 7 p.m. on weekends. Some housekeeping staff work from 4 p.m. to 8 p.m. on weekdays in the administrative office areas. There are no educational requirements for the housekeepers and floormen/projectmen positions.

In addition, the central supply clerk reports to the director of housekeeping. The central supply clerk distributes office and medical supplies and the mail, transports patients and staff to and from airports, appointments, community meetings, and court appearances, and cleans and maintains hospital vehicles. By virtue of his duties, he can come in contact with employees in numerous other job classifications. The Employer's requirements for the central supply clerk position are a high school diploma, a driver's license, and transportation experience. The parties agree that the central supply clerk is a nonprofessional employee.

The director of the environmental services (maintenance) department, who is also the Employer's safety officer, reports to Administrator Aranda. Four maintenance mechanics report to the director of environmental services. The maintenance mechanics maintain and repair the Employer's physical plant and grounds including electrical, heating, ventilation, and air-conditioning systems, plumbing fixtures and sanitary systems, and fire detection and firefighting equipment, and dietary kitchen equipment. They perform these maintenance and repair tasks throughout the Employer's facility. They work from 7 a.m. to 3 p.m., and they rotate ''on call'' for evenings and weekends. The Employer requires a high school diploma, or equivalent, and related building maintenance experience. The parties agreed that the maintenance mechanics are nonprofessional employees.

The manager of medical records-managed care, a stipulated supervisor, reports to Executive Director Hampton. Two medical transcriptionists, a medical records technician, a medical records clerk, and a word processor report to the manager of medical records-managed care. They work Monday through Friday, 8 a.m. to 4 p.m., or 9 a.m. to 5 p.m.

[46] The referral coordinator completes the first page, which contains patient and family identification data, and the patient finance counselor completes the second page, which contains insurance coverage and verification information. Contrary to the assertion in the Employer's brief that the patient finance counselor has ''significant work-related contact with referral coordinators,'' although these employees do complete portions of the same log/form, the record evidence does not reflect the degree or frequency of personal contact between these employees.

[47] In response to her counsel's questions regarding ''work-related contact'' among the various staff members employed in the business office, data processing, and medical records, Executive Director Hampton used such vague terms as ''interface'' and ''interact'' in her testimony which do not reflect the degree or frequency of such contact among unit employees.

The parties agreed that they are nonprofessional employees. The medical transcriptionists primarily transcribe three documents, the psychiatric admission and discharge summaries (dictate by a physician), and the psychosocial history (dictated by a social worker). In the course of their duties, they may need to contact a physician or social worker. The Employer has no educational requirements for the medical transcriptionist position, although a secretarial school graduate is preferred.

The medical records technician audits closed medical records (patient charts) for accuracy, completeness, and timeliness and notifies professional staff of deficiencies to be corrected, codes diagnoses for statistical purposes, and compiles data from medical records for reports. According to Executive Director Hampton, the medical records technician also selects documents from medical records for release pursuant to subpoenas issued to the Employer, and she must exercise independent judgment in this process.[48] In the course of her auditing duties, the medical records technician has contact with professional staff, primarily clinicians other than nursing staffs. The Employer requires a high school diploma and computer experience for the medical records technician. In addition, the Employer requires an ''accredited records technician'' (A.R.T) for the position.[49]

The medical records clerk processes legal admission papers, assembles discharge records, files and retrieves medical records, and performs other clerical tasks. The word processor extracts data from medical records for a variety of reports including daily census reports, monthly statistical reports, and quality assurance reports. The Employer requires a high school diploma and related experience for the medical records clerk and the word processor positions. The duties and responsibilities of these two positions do not require contact with any employees outside of the medical records department.

The director of the dietary department, also known as food services, reports to Executive Director Hampton. The parties stipulated that the director of dietary, and the supervisor of dietary who reports to him, are supervisors. The registered dietician and the dietary technician report to the director of dietary. The cooks and dietary assistants report to the supervisor and the director. The dietary department prepares and serves food for patients and staff, 7 days a week. The duties, responsibilities, and educational background of the registered dietician have been discussed above. The dietary technician spends about 35 to 45 percent of her time in the Employer's main kitchen overseeing the preparation and delivery of therapeutic diets and food preferences for patients. She also acts as a liaison between the dietary department and patients and staff regarding nonnutritional food service issues such as quality, service, and food preferences, and she visits the treatment units in that role. The Employer's requirements for the dietary technician are a Bachelor's degree in nutrition and food service, with experience preferred. The parties agreed that the dietary technician is a nonprofessional employee.

The dietary assistants assemble and distribute food in the patient/staff cafeteria and deliver trays to the treatment units for patients who are unable to leave the unit for meals.[50] They also wash dishes, clean, and maintain sanitary conditions in the kitchen and cafeteria, and process and store food and supplies. The cooks prepare and cook food in accordance with the therapeutic diets and ''house'' menus, maintain the cooking equipment, and proper inventory levels of food and supplies. The Employer's requirement for the dietary assistant and cook positions is a high school diploma or ''GED,'' with experience required for cooks. The parties agreed that the dietary assistants and cooks are nonprofessional employees. There are a total of 17 dietary assistants and cooks, who work full time or part-time schedules during the hours of 6 a.m. to 8 p.m., and there is one full-time dietary technician.

Several department heads have administrative assistants including the medical director and the director of clinical services, nursing, and community relations.[51] The Employer has no educational requirements for these positions but prefers graduates of accredited secretarial schools; the parties agreed that these administrative assistants are noprofessional employees. The administrative assistants perform a variety of administrative support services for their department heads, and they have contact with staff members of their department. The administrative assistant to the director of clinical services also performs administrative support services for the directors of psychology, social work, and creative therapeutic activities. As the administrative assistant to the director of community relations coordinates community relations conferences, meetings, and tours, she also has contact with clinicians other than nursing staffs.

In summary, the record evidence shows that some nonprofessionals have little, if any, work-related contact with other nonprofessionals and professionals, such as certain business office clericals. Some nonprofessionals have contact with both nonprofessionals and professionals in their immediate work areas, such as the unit receptionist and unit secretary. A clinical staff member has contact with the other clinicians assigned to his or her unit but has little contact with clinicians assigned to other units. Among professional employees, only RNs are assigned on a temporary basis to other units to ensure adequate staffing levels.

The director of human resources is responsible for staff recruitment. All staff vacancies are posted on the employee bulletin board. The director of human resources places advertisements in newspapers, checks references, and screens some applicants. Applicants are interviewed by department heads and may be interviewed by other supervisory staff. The director of human resources interviews all applicants who have accepted offers of employment prior to their hire date. She also checks New York State license requirements for all employees, other than nursing staffs and physicians.

The human resources department conducts a general orientation program for new hires. All staff must attend in-service training regarding fire safety/disaster and infection control, and professional and nonprofessional employees can attend these sessions together. In addition, each department

[48] The Employer's job description does not list this responsibility. In any event, no party asserts that the medical records technician is a professional employee and the record evidence provides no basis for such finding.

[49] Hampton was unable to testify as to how such accreditation is secured.

[50] Most patients eat their meals in the patient/staff cafeteria.

[51] As noted, the parties stipulated that the administrative assistants to Executive Director Hampton and to the director of human resources are confidential employees and excluded from any unit.

provides its own orientation for new hires. The nursing staffs development coordinator conducts a separate orientation program for new nursing staffs and provides in-service training for nursing staffs. Cardiopulmonary resuscitation (CPR) training is mandatory for nursing staffs only, and CPR reviews are offered annually. Management of the aggressive patient (MAP) training is offered periodically for all clinical staff members. The dual diagnosis unit offers in-service training once a month for its clinical staff members, which is held in lieu of a unit staff meeting.

Wages and benefits packages are administered by the human resources department. Through Executive Director Hampton, the Employer offered an exhibit regarding hourly wage rate ranges between RNs, or mental health workers, and other employees.[52] This exhibit contains nine statements regarding wage rate ranges, such as: ''Lowest hourly wage rate paid to RNs is lower than the lowest hourly wage rate paid to psychologists'' and ''The hourly wage rates of employees in the following classifications are within the range of hourly wages paid to RNs: dietician, referral coordinators, community relations representatives, eating disorder coordinator, educational coordinator, pharmacist.'' Hampton testified that she had directed the human resources department to provide the Employer's attorney with actual wage rates, the Employer's attorney prepared the exhibit based thereon, and Hampton reviewed the exhibit for accuracy. The hearing officer noted on the record that he had requested the Employer to provide the actual wage rates paid to employees. In the alternative, the hearing officer requested the Employer to provide percentage differences in the actual wage rates paid to employees. The Employer failed to provide any additional information and took the position that the record evidence regarding wages was ''adequate for the Region to make a determination in this proceeding.''

The Petitioner's attorney cross-examined Hampton on the contents of the Employer's wage rate range exhibit. The exhibit contains the following statement: ''Lowest hourly wage rate paid to an RN is higher than the lowest hourly wage rate paid to social workers, addictions counselor, and CTA therapists. Hampton testified that all RNs do not start at the same hourly wage rate, and that the statement may mean that there is only one RN who is paid this lowest hourly wage rate and there is only one social worker who is paid less than this one RN. The other statements regarding the RNs contain similar generalized comparisons without regard to the number of employees so affected. Although these statements show some overlap in wages between RNs and other professional employees, they provide insufficient information for a meaningful comparison of wage rates.

The Employer's wage rate range exhibit also contains the following statement: ''The hourly wage rate paid to some employees in the following classifications are lower than the hourly wage rate paid to some mental health workers: CTA therapists, social workers, addiction counselor.'' This generalized statement made about a single nonprofessional job classification, and without reference to the number of affected employees, does not provide support for a conclusion that professional and nonprofessional employees share a community of interest regarding wages. Moreover, although Director of Nursing Witt was unable to testify regarding the wage rates paid to mental health workers, she testified that 3 of the 37 mental health workers have completed medical school and are waiting to complete medical boards. If they are compensated for their additional education, their wage rates would skew any comparison. Of course, the Employer has sole possession of, and control over, wage rate information and could have avoided the need for conjecture elicited by its faulty exhibit.

Members of the nursing staffs are paid a shift differential for evening and night work. Executive Director Hampton testified that she did not know the dollar amounts for the differentials although she knew the night differential was higher than the evening differential. No other professional employees are paid a differential for evening and night work. RNs and the sole discharge planner are the only professional employees paid for overtime work.[53] The two admitting clerks who work from 4 p.m. to 12 midnight are paid the evening differential. For special projects, housekeepers and maintenance mechanics are paid a differential for evening and night work. The record evidence does not reflect the frequency of such special projects.

With regard to other benefits, all employees who work 20 hours or more a week accrue the same ''paid time off'' (p.t.o.) for holidays, sick leave, and personal leave. Nursing staffs are required to work four of the eight holidays. The CTA staff work two of the eight holidays. With regard to other clinical staff members, there are two clinical staff members on duty on holidays for each unit.[54]

Vacation leave is added to an employee's ''paid time off'' and the amount depends on job classification and years of service. ''Non-exempt'' employees, who are paid time-and-a-half for overtime work, receive 2 weeks' vacation at hire, 3 weeks after 5 years, and 5 weeks after 10 years. All nonprofessional employees are deemed ''non-exempt'' except for the dietary technician and some administrative assistants. Although deemed nonexempt employees, mental health workers and the accounts payable coordinator receive 3 weeks' vacation at hire, 4 weeks after 5 years, and 5 weeks after 10 years. ''Exempt'' employees, who are not paid for overtime work, receive 4 weeks' vacation at hire and 5 weeks after 5 years. Despite their nonexempt status, RNs and the discharge planner receive the additional vacation leave provided to exempt employees. All other professional employees are deemed ''exempt.''

Employees who work 32 hours or more a week receive health insurance benefits. There is a uniform policy for leave for bereavement, disability, jury duty, military service, and personal reasons. The Employer has a 401(k) plan and an educational reimbursement program for all employees.

All employees are subject to a 3-month probationary period and a progressive disciplinary system. All disciplinary actions are taken in consultation with the human resources department. All employees receive annual evaluations prepared by their department heads and are eligible for merit increases based thereon.

[52] See Emp. Exh. 70, ''Hourly Wage Rate Range Comparison of Non-Per Diem Incumbent Employees.''

[53] Executive Director Hampton testified that she was ''not positive'' whether CTA staff members were paid for overtime work and she would have to check on it; however, she did not supplement her testimony later thereon.

[54] On Thanksgiving and Christmas, there is only one clinical staff member on duty.

As noted, the parties stipulated that the Employer is a psychiatric hospital as defined in the Board's Final Rule on Collective-Bargaining Units in the Health Care Industry. The Board's rule provides for eight presumptively appropriate bargaining units in health care facilities, including a separate unit of all registered nurses. The Board determined that the rule would apply only to acute care hospitals and that bargaining unit determinations for psychiatric hospitals and other nonacute care facilities would continue to be made on a case-by-case basis. In *Park Manor Care Center*,[55] the Board provided the method of analysis for bargaining unit determinations in nonacute care facilities. Characterized as a ''pragmatic or empirical community of interests approach,'' the Board considers background information gathered during its rulemaking process, prior precedent involving the type of unit sought or the particular type of health care facility and traditional community-of-interest factors.[56] The Board also will consider a comparison of the work force at the nonacute care facility with those at acute care hospitals. In exercising its discretion to determine an appropriate unit, the Board will be guided by the principle that it should avoid finding a unit that is either too large or too small due to the undesirable consequences to the parties.

The Petitioner asserts that separate units of all registered nurses, and all nonprofessional employees, constitute appropriate units at the Employer's psychiatric facility. The Employer contends that the only appropriate unit at its facility is a single, wall-to-wall unit of all professional and nonprofessional employees. Applying the *Park Manor* method of analyis for the bargaining unit determination herein, I find that separate units of all registered nurses, and all nonprofessional employees, constitute appropriate units herein.[57]

The rulemaking process produced evidence that the distinct functions and collective-bargaining interests of RNs at acute care hospitals compelled the conclusion that a separate unit of RNs was warranted there. Unlike other professionals, the Board found that RNs have a professional responsibility which requires them as a group to work 24 hours a day, 7 days a week, and subjects them to mandatory overtime. Whereas other professionals specialize and have intermittent contact with patients, RNs have continuous interaction with patients. The nursing process involves the continuous assessment and monitoring of the patient's status. RNs have special responsibilities related to the administration of medication to patients. RNs have an organized department of nursing and are supervised by RNs. There is a distinct labor market for RNs which affects their wages, and a severe nursing shortage which affects their working conditions.

In addition to their specialized education and training, RNs must pass state licensing examinations. Such licensing requirements and other regulations preclude the cross-training or interchange among RNs and other professionals; RNs cannot be replaced by other professionals. The lack of cross-training and interchange, in combination with different working hours, minimizes the contact between RNs and other professionals. Although some acute care hospitals use multidisciplinary treatment teams, the team members interact only with the few other members of their team; the RNs' other duties may limit or prevent their participation with the team's activities; and the team approach does not alter each professional's scope of practice.

The Board also found that RNs have sought separate representation for many years, and other professionals have not reacted favorably to their inclusion with RNs for collective-bargaining purposes. In acute care hospitals, the other professionals fear not having their interests given priority as they are far outnumbered by RNs. RNs have several issues of unique concern to them such as staffing, scheduling, shift differentials, mandatory overtime, and floating. The Board concluded that separate RN units have not led to wage whipsawing, jurisdictional disputes, or more strikes, and they have had no adverse effects on multidisciplinary team care.

With regard to psychiatric hospitals, the rulemaking process produced evidence that as they do not provide patient care for the physically ill, RNs are not the primary facilitators of health care there. The RNs' work is closely integrated with the work of other professionals in the treatment plan designed for the patient. Unlike acute care hospitals, RNs do not outnumber other professionals and there are more ''paraprofessionals'' (e.g., mental health workers) and other employees who are trained to relate to patients.

A review of the factors which supported the Board's decision to permit separate RN units at acute care hospitals, with an analysis of the work of RNs at the Employer's facility, compels the conclusion that the Employer's RNs have distinct functions and collective-bargaining interests. The Employer's RNs are the sole professional employees who are responsible for providing patient care 24 hours a day, 7 days a week, 365 days a year, on all four units. The State of New York and the Joint Commission require that every nursing unit has at least one RN in charge at all times. Although some other professionals work into the evening shift (social workers who work one evening a week until 9 p.m.), and some other professionals work 1 day on the weekends (CTA staff members), no other professionals cover the patient units 24 hours a day and 7 days a week. No other professional employees are subject to a mandatory overtime policy or receive overtime pay. No other professional group relies so heavily on per diem employees. Thus, the RNs' unique staffing responsibilities lead to special bargaining interests such as staffing, scheduling, shift differentials, mandatory overtime, and floating.

Although the focus of the patient care delivered at the Employer's facility is on mental illness and not physical illness, the RNs provide professional nursing care utilizing nursing methods and techniques which include the nursing process. Within 8 hours of admission, the RN must complete a nursing assessment record which is a detailed medical history of the patient's physical and mental health and includes the initial nursing care plan for the patient. On the day and evening shifts, one RN is assigned as the charge nurse and one RN is assigned as the medication nurse. The night-shift RN must function in both roles. On every shift, each patient is assigned an RN or mental health worker as his or her ''primary contact'' for the shift. On every shift, an RN must complete a patient acuity assessment form and RNs complete patient care monitoring forms. RNs must make entries on the patient's progress notes a minimum of once every 24 hours.

[55] 305 NLRB 872 (1991).

[56] Id. at 873.

[57] See *McLean Hospital Corp*., 311 NLRB 1100 (1993), here the Regional Director applied the *Park Manor* method of analysis and found a separate RN unit appropriate at a psychiatric facility, and the Board refused to grant the employer's request for review thereon.

RNs complete vital signs forms and observation flow sheets. No other professional group has responsibility for such extensive patient status documentation.

At the Employer's facility, the medication nurse's principal function is the administration of medication on his or her unit. No member of any other professional job classification in the bargaining unit is allowed to administer medication. The RN must comply with the extensive procedures and documentation contained in the Nursing Policy Manual regarding the administration of medication. Virtually all patients on the intensive treatment unit take medication, as do most patients on the dual diagnosis unit; and medication is dispensed on the other units as well. RNs must teach patients about their medication. RNs must report and document medication errors and any adverse drug reactions. Other than physicians, RNs are the only professionals who must be trained in cardiopulmonary resuscitation, respond to a ''code blue,'' initiate intravenous therapy, prepare and monitor a patient for electroconvulsive thereapy, initiate seclusion or restraint, initiate a ''code white,'' and must respond to a ''code white'' on other units. Because of the RNs many distinct functions and responsibilities, no other professionals can replace an absent RN on any unit. The RNs are segregated in the department of nursing and are separately supervised by RNs, who report to the director of nursing. No other professionals report to the director of nursing. The other clinical professionals report to their respective department heads, who along with program directors, report to the director of clinical services.

The multidisciplinary treament team approach utilized at the Employer's facility encourages collaboration and cooperation among all members of the treatment team. The team members meet in clinical rounds, attend staff meetings, colead groups, ''team'' patients, and monitor ''contracts'' together. However, the professional contact associated with the multidisciplinary treatment team approach primarily affects RNs assigned to the day shift, as there is minimal contact between RNs and other professionals on the evening shift and virtually one on the night shift. Although RNs probably have more contact with the professionals assigned on their units than they do with RNs assigned to other units, this is true for the other professional job classifications as well. However, RNs are the only professional employees who are, assigned temporarily to other units for a shift or part of a shift due to staffing needs. The Board does not require that all members of a bargaining unit have contact with each other. At the Employer's facility, the application of such a requirement could lead to a conclusion of four separate bargaining units, one for each unit. Moreover, a review of the record evidence comparing the duties and functions of the Employer's RNs with its other clinical professionals supports the conclusion that the pivotal role of the RNs in the delivery of patient care remains unique in this psychiatric facility.[58]

With respect to comparison of wages, the Employer provided insufficient information for a meaningful comparison of wage rates between RNs and other professionals. Rather than provide actual wage rates or percentage differences in wage rates, the Employer provided nine statements of generalized comparisons between job classifications without regard to the number of employees so affected. These statements show some overlap in wages between RNs and other professionals. RNs receive a shift differential for evening and night work. No other professionals are paid a differential for evening and night work. RNs, and the sole discharge planner, are the only professional employees who receive overtime pay. Various personnel policies are applied uniformly to all employees, including the use of annual evaluations to determine eligibility for merit increases. Regarding benefits, all employees accrue the same ''paid time off'' for holidays, sick leave, and personal leave. However, the Employer does make some distinctions between professional and nonprofessional employees regarding vacation leave, as well as between certain job classifications among the nonprofessional employees. The remaining fringe benefits are applied uniformly to all employees.

Based on the foregoing, and the record evidence as a whole, I find that the Employer's RNs have distinct functions and collective-bargaining interests which establish that they share a substantial community-of-interest which sets them apart from the Employer's other professional and nonprofessional employees.

A review of Board precedent prior to rulemaking regarding separate RN units also supports the conclusion of the appropriateness of a separate RN unit herein. From 1974 through 1984, applying the traditional community of interests analysis, the Board consistently approved separate RN units.[59] After the Board's adoption of the disparity-of-interests test, the Board found separate RN units inappropriate in several cases.[60] However, during the rulemaking process with its consideration of substantial empirical evidence regarding RNs' functions, training, and interests, the Board observed that it might well have reached a different result in *St. Vincent*.[61]

In *Mount Airy Psychiatric Center*,[62] the Board refused to find a separate RN unit appropriate and directed an election in an all professional unit. There, RNs and other professionals in the job categories of ''team leader'' and ''charge person'' peformed virtually the same duties; and the team leaders worked 24 hours a day, substituted for each other, and had the same supervision and the same benefits. In addition, the RN team leaders did not have any separate responsibility for administering medication.[63] In these cir-

[58] See *McLean*, where the Regional Director found that the staff RNs assigned to the the multidisciplinary treatment teams had frequent contact with the other professional members of the teams through various clinical meetings and through coleading therapy groups, yet she found a separate RN unit appropriate therein. The Regional Director also found that a separate RN unit would not impact adversely on the multidisciplinary treatment team approach or on the maintenance of therapeutic milieu there. Although McLean is a much larger psychiatric facility, the Employer's RNs function similarly to the McLean staff RNs assigned to multidisciplinary treatment teams.

[59] See *Mercy Hospitals of Sacramento*, 217 NLRB 765 (1975), for the Board's reasoning related thereto.

[60] See *Keokuk Area Hospital*, 278 NLRB 242 (1986); *North Arundel Hospital Assn.*, 279 NLRB 311 (1986); *St. Vincent Hospital*, 285 NLRB 365 (1987).

[61] 284 NLRB 1580, 1515 (1989).

[62] 253 NLRB 1003 (1981). Prior to the Board's rulemaking, *Mount Airy* is the only Board decision involving RNs in a psychiatric hospital.

[63] The Board noted that an RN's license to make medical assessment and to administer medication might be a crucial factor in find-

cumstances, the Board concluded that the exclusion of non-RN team leaders from the unit would be inappropriate. The Board also included the nine remaining professionals in the unit as otherwise they would constitute a small residual unit without a strong community of interest. Unlike the RNs at Mount Airy, the Employer's RNs and other professionals do not share job titles, do not perform virtually the same duties, do not have the same supervision, and do not work side-by-side 24 hours a day. No other professional can substitute for an RN at the Employer's facility, and the RNs do have responsibility for administering medication.

In *Newton-Wellesley Hospital*,[64] the Board found a separate RN unit to be appropriate in an acute care hospital with psychiatric units. The Board cited in support of its conclusion the following factors: the RNs' possession of a license and their similar education and training; their ability to interchange among the hospital's units; their sole responsibility to serve in a ''charge'' capacity and to give and receive intershift reports; and their unique responsibility or patient care 24 hours a day. With respect to the RNs on the psychiatric units, the Board rejected the contentions that other professionals should be included in their unit despite its finding that the RNs had frequent and substantial contact with other professionals. In excluding the professional job classification of ''mental health counselor'' from the RN unit, the Board found that although mental health counselors performed work similar to the RNs, worked 24 hours a day, and shared clinical supervision, the two groups were ''not equivalent.''[65] The foregoing factors cited by the Board in support of its conclusion of the appropriateness of a separate RN unit at Newton-Wellesley all apply to the RNs employed in the Employer's facility as well.

Contrary to the Employer's assertions in its brief, the finding of a separate RN unit herein does not create a small residual unit of professional employees. Based on the Employer's staffing figures, the ''regular'' RNs are outnumbered by the other professional employees.

With regard to the Employer's assertions in its brief that its nonprofessional employees share a strong community of interest with its professional employees so as to warrant their inclusion in a single, wall-to-wall unit, beyond the evidence of some contact among certain nonprofessionals and professionals, and some overlap in wages between some mental health workers and some professionals, the record evidence falls short of providing support for the Employer's argument. A review of traditional community-of-interest factors such as skills, training, education, job duties and functions, employee interchange and functional integration, regarding job classifications such as psychologist and unit receptionist, or registered dietician and admitting clerk, or social worker, and housekeeper, clearly reveals the appropriateness of a separate unit of nonprofessional employees.

Moreover, the finding of a wall-to-wall nonprofessional unit, along with the separate RN unit, complies with the Congressional policy against undue proliferation of bargaining units in the health care industry as it appears that there can be only one additional appropriate unit at the Employer's facility, that is, a unit of all professional employees excluding RNs.

. . . .

Based on the foregoing, and the record evidence as a whole, I find that per diem employees share a sufficient community of interest with unit employees. As the Employer offered no evidence of special circumstances to warrant a departure from the Board's standard eligibility formula for ''on-call'' employees, I find that per diem employees are eligible to vote if they average 4 or more hours of work per week in the calendar quarter (13 weeks) immediately preceding the eligibility date herein.[76]

Accordingly, I find that the following separate units of employees constitute appropriate units for the purposes of collective bargaining within the meaning of Section 9(b) of the Act:

> All full-time and regular part-time[77] registered nurses, including Senior Nurses, employed by the Employer at its Holliswood, Queens, New York location, excluding the Director of Human Resources, Director of Community Relations, Director of Intake/Referral, Director of Housekeeping, Director of Environmental Services, Director of Food Services, Director of Pharmacy, Director of Clinical Services, Director of Psychology, Director of Social Work, Director of Creative Therapeutic Activities, Director of Nursing, Nursing Care Coordinators, Clinical nursing Supervisors, Staff Development Coordinator, Program Director, Business Office Manager, Benefits Office Supervisor, Accounts Receivable Supervisor, Manager of Medical Records/Managed Care, Admitting Supervisor, Data Processing Supervisor, Food Services Supervisor, all other professional employees, nonprofessional employees, managerial employees, guards and supervisors as defined in the Act.
>
> All full-time and regular part-time[78] nonprofessional employees, including mental health workers, licensed practical nurse, unit secretaries, unit receptionists, admitting clerks, receptionists, switchboard operators, patient finance counselors, patient accounts representatives, senior patient accounts representatives, accounts payable coordinators, payroll representatives, data processing clerks, housekeepers, floormen/projectmen, central supply clerks, maintenance mechanics, medical transcriptionists, medical records technicians, medical records clerks, word processors, dietary technicians, cooks, dietary assistants, and the administrative assistants to the Medical Director and the Directors of Clinical Services, Nursing and Community Relations, employed by the Employer at its Holliswood, Queens, New York location, excluding the administrative assistants to the Executive Director and to the Director of Human Resources, Director of Community Relations, Director of Intake/Referral, Director of Housekeeping, Director of Environmental Services, Director of Food

ing a separate RN unit appropriate in other circumstances. 253 NLRB at 1006.

[64] 250 NLRB 409 (1980).

[65] 250 NLRB at 414.

[76] *Davison-Paxon*, 185 NLRB 21; and *Sisters of Mercy Health Corp*., 298 NLRB 483 (1990).

[77] Employees who average 4 or more hours of work per week in the calendar quarter (13 weeks) immediately preceding the date of issuance of this Decision and Direction of Election shall be eligible to vote.

[78] Id.

Services, Director of Pharmacy, Director of Clinical Services, Director of Psychology, Director of Social Work, Director of Creative Therapeutic Activities, Director of Nursing, Nursing Care Coordinators, Clinical Nursing Supervisors, Staff Development Coordinator, Program Director, Business Office Manager, Benefits Office Supervisor, Accounts Receivable Supervisor, Manager of Medical Records/Managed Care, Admitting Supervisor, Data Processing Supervisor, Food Services Supervisor, pharmacist, biofeedback therapist, registered dietician, discharge planner, physicians, social workers, psychologists, referral coordinators, community relations representatives, education coordinator, eating disorder coordinator, addiction counselor, art therapists, dance/movement therapists, occupational therapists, recreation therapists, all other professional employees, managerial employees, guards and supervisors as defined in the Act.